r		TMENT OF HEALTH RS FOR MEDICARE	ANDAN SERVICES & MEDICAID SERVICES 4	54	6/04/11	FORM): 04/21/2011 MAPPROVED): 0938-0391
1		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S	
			445071	B. WING		04/:	20/2011
	NAME OF P	ROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZI		
	CLAIBOR	RNE COUNTY NURSIN	NG HOME		CEWELL, TN 37879		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	SS=D	An individual resider the interdisciplinary §483.20(d)(2)(ii), ha practice is safe. This REQUIREMENT by: Based on medical reand interview, the faresident (#12) was a administration of a residents reviewed. The findings include Resident #12 was accepted and Congestive Heart Faresident April 19, 2011, Albuterolq(every) alberterol routine" Observation of resident in the on position of the properties	nt may self-administer drugs if team, as defined by as determined that this IT is not met as evidenced ecord review, observation, acility failed to assure one assessed prior to self medication of twenty-four ed: dmitted to the facility on the diagnoses including ailure and Asthma. Ew of a Physician's Order, revealed, "add 4 (four) hourscontinue ent #12 in the resident's room 9:25 a.m., revealed a ed around the resident's tion and no facility staff in the esk on April 19, 2011, at 9:40 1 placed the nebulizer mask, machine to the on position,	F 176	F 176 Resident #12, affect deficient practice, reducation and the cetthe Self Administration of hands assessment by the Radministration of hands accessful in meetire established criteria afor self administration held nebulizer treatments of the self administration of Completion: 04/ The licensed staff midentified as involved deficient practice where the Director of National midentified as involved deficient practice where the Director of National midentified as involved deficient practice where the Director of National midentified as involved deficient practice where the Director of National midentified as involved deficient practice where the Director of National midentified as involved deficient practice where the Director of National middle procedure stressed at Date of Completion 100% of the license staff will be educated importance of completion of the procedure of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated importance of completion of the license staff will be educated in the license staff will be	ted by this eccived completion of tion form a.N. for self and held as on the sent # 12 was ag the and approved on of hand ments after a medication vice. Date 19/2011 The member end in the case educated dursing on the oliance with procedures, a Self cy and at this time. 1. 04/19/2011 In the control of t	4/19/2011
			inside the plastic cylinder, oulizer mask and left the		facility policies and		
A	BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	11 124	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND MAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONS	STRUCTION	(X3) DATE :	
			445071	B. WIN	G		04/	20/2011
	PROVIDER OR SUPPLIER RNE COUNTY NURSI	NG	номе		1850 OLD	RESS, CITY, STATE, ZIP CODE KNOXVILLE ROAD LL, TN 37879		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
	An individual reside the interdisciplinary §483.20(d)(2)(ii), he practice is safe. This REQUIREMENT by: Based on medical rand interview, the faresident (#12) was administration of a residents reviewed. The findings include Resident #12 was a October 7, 2010, wire Congestive Heart Famelia and Congestive	nt reteased of the second of t	nay self-administer drugs if m, as defined by etermined that this is not met as evidenced or dreview, observation, y failed to assure one essed prior to self lication of twenty-four tted to the facility on iagnoses including e and Asthma. If a Physician's Order vealed, "add bur) hourscontinue #12 in the resident's room 5 a.m., revealed a	F 1	with Self the Latte will sign Date 100% order nebugabilis The will for education for a self-Assi respective of Hamiltonian to the control of	DEFICIENCY) 6 Cont'd. 6 Complession process Director of Nursing. 6 Completion: 05/3 6 Completion: 05/3 7 Completion: 05/3 7 Completion: 05/3 8 Completed by the mean pulicable Resident proval or disapproval administration of HHN stant Director of Nursionsible for oversight of ess. Date of Completing 1/2011 8 Complete a 100% of HHN orders for Resident pulicable for Resident pu	ession ants' sheet. 1/2011 ve held ave of on. orm urse nt with results I for N. The ng is f this ion:	5/31/2011
t F	a.m., revealed RN # urned the nebulizer placed the Albuterol and attached the net	l pla mad insi ouliz	aced the nebulizer mask, chine to the on position, de the plastic cylinder, er mask and left the	ATURE	comp Adm	pletion of the Self inistration form. The ber of residents' having		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	ОИ ((X3) DATE SURVEY COMPLETED	
		445071	B. WING		21	04/20/2011	
1	PROVIDER OR SUPPLIER RNE COUNTY NURSI	NG HOME	18	EET ADDRESS, CI 50 OLD KNOXVI AZEWELL, TN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTI RRECTIVE ACTION SHOUL ERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 176 SS=D	An individual reside the interdisciplinary §483.20(d)(2)(ii), ha practice is safe. This REQUIREMENT by: Based on medical read interview, the faresident (#12) was a administration of a residents reviewed. The findings include Resident #12 was a October 7, 2010, with Congestive Heart Fallouterolq(every) Albuterolq(every) Albuterolq(ev	Int SELF-ADMINISTER D SAFE Int may self-administer drugs if team, as defined by as determined that this IT is not met as evidenced ecord review, observation, acility failed to assure one assessed prior to self medication of twenty-four It is not met as evidenced ecord review, observation, acility failed to assure one assessed prior to self medication of twenty-four It is not met as evidenced ecord review, observation, acility failed to assure one assessed prior to self medication of twenty-four It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma. It is not met as evidenced ecord review, observation, acility on the diagnoses including ailure and Asthma.	F 176	completed form and pof meeting established total numborders for compliance and procest Administrative Expected a monthly be Director of audit will Administrative Nursing arthrough the Committee or until 10 achieved a Responsible and Assistantian and Assistantia	t'd. I Self Administration proper documentate or not meeting the discrete divided between of residents' with HIN will yield the rate with the political proper documentate of Self ation of Medication compliance is 100% liance data will be and aggregated by the Assistant of Nursing. Results be reported to the ator, Director of and Medical Director of and Medical Director of and Medical Director of the compliance is and sustained. The persons: Direct ant Director of the Date of Completion Date of Completion	on tion to be by the tith the ticy on. 2%.	
1 1	a.m., revealed RN #* turned the nebulizer placed the Albuterol and attached the neb	k on April 19, 2011, at 9:40 I placed the nebulizer mask, machine to the on position, inside the plastic cylinder, bulizer mask and left the					
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	Ti	TLE	(X6) DATE	

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VVMW11

Facility ID: TN1301

If continuation sheet Page 1 of 6

DEPARTMENT OF HEALTH AND MAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

03/04/2011 MDD 13.31 FMA

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		445071	B. WING		04/20/2011
o no somethor reservation	PROVIDER OR SUPPLIER RNE COUNTY NURSI	NG HOME	18	REET ADDRESS, CITY, STATE, ZIP CODE 850 OLD KNOXVILLE ROAD AZEWELL, TN 37879	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
SS=D	room. Interview with the fa (MDS) coordinator on April 19, 2011, a resident had not be administration of m administration. 483.15(h)(1) SAFE/CLEAN/COMENVIRONMENT The facility must procomfortable and ho the resident to use to the extent possib This REQUIREMENT This REQUIREMENT This REQUIREMENT The facility must procomfortable and ho the resident to use to the extent possib This REQUIREMENT The finding include an objectionable odors twenty-four sampled tour on April 18, 201 resident in the room urine odor was noted. Observation on April revealed resident #4 continued to have a	acility Minimum Data Set at the first floor nurse's desk, at 9:45 a.m., confirmed the een assessed for self hedications prior to self MFORTABLE/HOMELIKE ovide a safe, clean, omelike environment, allowing his or her personal belongings ble. NT is not met as evidenced on and interview the facility environment free of for one resident (#4) of diresidents. ed: dent #4's room during initial 11, at 10:20 a.m., revealed no at that time and a strong d. 11 19, 2011, at 9:00 a.m., 1 lying in bed and the room strong urine odor.	F 176	F252 Immediately after nursing housekeeping aware of the deficient practice involving Resident # 4's room with odor, the mattress was che and a very small opening cover was identified. The mattress was immediately replaced and the foul odor eliminated. Date of Completion: 04/19/2011. 100% of resident mattress be inspected for any crack openings in the mattress of direct care staff when chabed linen. Any openings of mattress cover are to be reto the Director of Nursing immedior replacement. Respons person: Director or Assistar	a foul ecked of the r was #//9/2011 ses will as or cover by nging of eported nt ediately sible ant
1	revealed the residen	I 19, 2011, at 10:45 a.m., at was no longer in the room lined.		Director of Nursing. Date Completion: 04/22/2011	e of 4/22/24/1

DEPARTMENT OF HEALTH ANL MAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE S COMPL		
		445071	B. WING		04/2	20/2011
	PROVIDER OR SUPPLIER RNE COUNTY NURSI	NG HOME	18	EET ADDRESS, CITY, STATE, ZIP CODE 50 OLD KNOXVILLE ROAD AZEWELL, TN 37879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
SS=D	Interview with the facility must precomfortable and hot the resident to use to the extent possible. This REQUIREMENT Based on observationable odors twenty-four samples to unine odor was note to the resident in the room urine odor was note to bservation on April 18, 200 revealed resident #2 continued to have a Observation on April 200 per valionable of the resident in the room urine odor was note to the extent possible odors twenty-four samples to the findings included the provided and prevention of the resident in the room urine odor was note to the extent possible odors the findings included the findings included to be a prevention on April 18, 200 resident in the room urine odor was note to the prevention on April 200 per valion on April	acility-Minimum Data Set at the first floor nurse's desk, at 9:45 a.m., confirmed the een assessed for self edications prior to self AFORTABLE/HOMELIKE Ovide a safe, clean, melike environment, allowing his or her personal belongings ble. AT is not met as evidenced on and interview the facility environment free of for one resident (#4) of d residents. ed: lent #4's room during initial 11, at 10:20 a.m., revealed no at that time and a strong d. It 19, 2011, at 9:00 a.m., It lying in bed and the room strong urine odor. It 19, 2011, at 10:45 a.m., at was no longer in the room	F 176	F252 Cont'd. 100% of direct care staff of educated by the Director of Nursing on the importance proper inspection of mattree when performing linen chatto identify and immediate report any openings of the mattress cover to the shift supervisor so mattress car replaced. Date of Completion: 05/3 Housekeeping Supervisor perform random monitor or residents' mattresses weel ensure cleanliness and into cover. The Supervisor will her findings and provide of the Director of Nursing we for aggregation and trending mattresses checked that are and odor free with intact of total # of mattresses monitrate of compliance. The residence.	of e of resses sanges sly e b 1 be 81/2011 to of kly to act 1 log lata to eckly ng. # of re clean cover / tored =	5/31/2011

DEPARTMENT OF HEALTH AND JUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTI G	ION	(X3) DATE SURVEY COMPLETED
		445071	B. WING _			04/20/2011
10	PROVIDER OR SUPPLIER RNE COUNTY NURSI		1:	REET ADDRESS, CI 850 OLD KNOXV AZEWELL, TN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT DRRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	Supervisor on April confirmed the foul of contacted houseker. Interview with the H at 11:00 a.m., confifrom the resident's wash the mattress. Observation on Aprirevealed the room rodor after the mattre 483.25(d) NO CATHRESTORE BLADDI Based on the reside assessment, the fact resident who enters indwelling catheter i resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident to as possible. This REQUIREMEN by: Based on medical refacility failed to compassessment and devices and the compassessment and devices and contact and compassessment and devices and contact and compassessment and devices and contact an	IN (Registered Nurse) 19, 2011, at 10:50 a.m., odor and immediately eping. Iousekeeper on April 19, 2011, rmed the odor was coming mattress and proceeded to ii 19, 2011, at 3:00 p.m., no longer had an objectionable ess was cleaned. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the indition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder of the cord review and interview the colete a bowel and bladder velop an individualized	F 315	monthly to Medical D Quality Market Medical D Quality Market Medical End of the Sustained. Is 100%. R Director of Date of Co F315 The MDS a Bowel at and an indeprogram we Resident # deficient p Date of Co 100% of the assessed for Bowel and form compindividual implement Responsib	or will be reported to Administrator and Director through the lanagement Comminonths or until 100 to achieved and Expected compliance Responsible person of Nursing completion: 05/31/2 Coordinator complete Bladder assess dividualized toileting was established for #13 identified in the	d d d d d d d d d d d d d d d d d d d
	residents reviewed. The findings include	resident (#13) of twenty-four			on: 05/31/2011	5/31/2011

DEPARTMENT OF HEALTH AND LUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		0.000	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445071	B. WING	i		04/:	20/2011
CLAIBO	PROVIDER OR SUPPLIER RNE COUNTY NURSI		S	1850 OLD K	ESS, CITY, STATE, ZIP CODE NOXVILLE ROAD L, TN 37879		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EA	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
SS=D	Interview with the R Supervisor on April confirmed the foul of contacted houseked Interview with the H at 11:00 a.m., confirmed the resident's wash the mattress. Observation on April revealed the room rodor after the mattre 483.25(d) NO CATHRESTORE BLADDE Based on the resident who enters indwelling catheter is resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident to as possible. This REQUIREMEN by: Based on medical refacility failed to compassessment and devices the facility failed to compasses the facility failed to compasse the facility failed to compasse the facility failed to compasse the facility fa	N (Registered Nurse) 19, 2011, at 10:50 a.m., bdor and immediately eping. Ousekeeper on April 19, 2011, rmed the odor was coming mattress and proceeded to il 19, 2011, at 3:00 p.m., to longer had an objectionable ess was cleaned. HETER, PREVENT UTI, ER nt's comprehensive fility must ensure that a the facility without an as not catheterized unless the notition demonstrates that the essary; and a resident fibladder receives appropriate test to prevent urinary tract tore as much normal bladder T is not met as evidenced cord review and interview the blete a bowel and bladder recipe an individualized resident (#13) of twenty-four	F 31	F315 100% educacomp proces assess of ine applicare imposindiv properation of the conference of the co	6 of the licensed staff ated on the importance olying with the policy edure of Bowel and Blusment and the develop dividual toileting plantcable. 100% of the distaff will be educated retance of complying vidualized toileting planter documentation. Stadance will be verified eipants' signatures on idance sheet. Education impleted by the Direct ing. Date of Completi /2011. toring compliance with mined by aggregating ted by the MDS dinator. # of completed land bladder assessmesident charts reviewed liance rate. Expected in mined compliance with the mined complia	e of and ladder oment s if rect on the with ms and off by on will or of ion: the be data ed ents / ed = rate of the illeting ith	5/31/2011

RN002/074

DEPARTMENT OF HEALTH AND . JMAN SERVICES

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Ì
		445071	B. WING	3	04/20/2011	
*	ROVIDER OR SUPPLIER	L.	18	EET ADDRESS, CITY, STATE, ZIP 850 OLD KNOXVILLE ROAD AZEWELL, TN 37879		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION DATE	N
F 315	Resident #13 was a March 17, 2011, when the facility must est in fection Control Psafe, sanitary and in fection Control Psafe, sanitary and in fection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control Psafe, sanitary and ito help prevent the of disease and infection Control (a) Infection Control Psafe, sanitary and ito help prevent the of disease and infection Control (b) Infection Control (c) Infection Control (c) Infection Control (d) Infection Control (d) Infection Control (e) Infection Control (f) Investigates, control (admitted to the facility on ith diagnoses including ongestive Heart Failure. record review of the Minimum ited March 17, 2011, revealed aking self understood, no retanding others and was inent of bowel and urine. Ical record review with the inator, in the facility dining 2011, at 2:01 p.m., confirmed on been assessed for a bowel am, and an individualized ad not been developed. N CONTROL, PREVENT Stablish and maintain an rogram designed to provide a comfortable environment and development and transmission action. Of Program stablish an Infection Control ich it - ontrols, and prevents infections rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. The add of Infection tion Control Program resident needs isolation to the facility must	F 315	rate. Exportion of compliance rate. Exportion of compliance is 1000 will be aggregated and monthly for three monthly for the Director of Norwald Management Committee of Completion: 05/3 F441 Immediately after the became aware of the practice involving Rethe improperly stored equipment was remondisposed of. New sure equipment was placed residents' room in the storage container by Date of Completion: 100% of residents wis suctioning were review proper storage of equipment was placed container by the Director of Nursing, were properly stored Completion: 04/19/2	26. Data and reported on this to the edical stor of Quality stee. Date 1/2011 27 and reported on the edical stor of Quality stee. Date 1/2011 28 and consider #2 disuction wed and cotion sed in the edical story of the nurse. 04/19/2011 29 and consider for ewed for simple tin a he Assistant All others All others Date of	,,,

DEPARTMENT OF HEALTH AND JMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE CONS	TRUCTION	COMPLI	
		445071	B. WIN	G		04/2	0/2011
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSING HOME			1850 OLD	RESS, CITY, STATE, ZIP CODE KNOXVILLE ROAD L, TN 37879			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(E	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	(2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each dith hand washing is incorprofessional practice. (c) Linens Personnel must har	t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted	F 4	F441 100% re-ec prop equip Nurs educ partic Atter	6 of the licensed staff valucated on the important of suctioning oment by the Director of the companion will be verified by cipants' signature on the dance sheet. Date of pletion: 05/31/2011	nce of g of	5/31/2011
	by: Based on observation failed to maintain satcatheter for one respective residents reviewed. The findings include Resident #2 was read January 31, 2011, which was a second reviewed. Medical record reviewed attention to all accepted nutrition the endoscopic endoscopic observation during the sate of the	admitted to the facility on vith diagnoses including Joint imer's Disease, and ew of the Minimum Data Set 1, revealed the resident was tivities of daily living and rough a percutaneous opic gastrostomy (PEG) tube.		deter cathe close total equip comp 100% round be us data. provi of Nu and r Adm Direct mont	mined by # of suction ters properly stored in d container/ # of residents with such the container with such the container. Expected to be a contained to be a contained to be a contained to the compliance is expected to be a contained to gather the compliance of the charge Nurses will de the data to the Direct the compliance rate the compliance rate the compliance rate the compliance rate the compliance of the contained the compliance rate the	of e s will cance ll ctor ate it	N. Control of the Con
		t's room revealed the resident ne with clear liquid in the			ompletion: 05/31/2011		5/31/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTR	UCTION	(X3) DATE SU	
		445071	B. WING _			04/20	0/2011
NAME OF PROVIDER OR SUPPLIER CLAIBORNE COUNTY NURSING HOME				850 OLD KN	SS, CITY, STATE, ZIP CODE OXVILLE ROAD , TN 37879		240550
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECT OF CORRECTIVE ACTION SHOP CORRECTIVE ACTION SHOP CORRECT TO THE APPOPULATION OF	OULD BE	(X5) COMPLETION DATE
F 441	container, sitting of Continued observatubing had the such tubing placed under any type protection. Observation on App.m., and 1:20 p.m. revealed the suction the clear liquid in the catheter was place without any type of catheter. Interview on April 1:41 (registered nurse confirmed the suction plastic bag for prot suction container had pril 20, 2011, at 9	n a bedside night stand. ation revealed the suction stion catheter attached to the er the suction machine without n of the suction catheter. oril 19, 2011, at 8:30 a.m., 12:40 n., in the resident's room on container continued to have the container and the suction and under the suction machine of protection of the suction 19, 2011, at 1:20 p.m., with RN se), in the resident's room, tion catheter was to be in a tection and confirmed the had not been emptied. Assistant Director of Nursing on 0:55 a.m., in the hallway, tion catheter was to be in a	F 441				